Employers Dental Services

A Company of the Principal Financial Group

Principal® Financial Group

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Member Name:_____

EDS Member Number: _____ Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's protected health information as described below.
2. The following individual or organization is authorized to make the disclosure:

_____

Name Address

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ☐ Treatment plan
- ☐ Health history
- ☐ Chart documentation with x-rays
- ☐ Billing statement with CDT codes
- ☐ Entire dental record
- ☐ Other_____

4. I understand that the information in my dental record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services.
5. This information may be disclosed to and used by the following individual or organization:

   Employers Dental Services
   4720 N Oracle Road, Suite 100
   Tucson, Az 85705

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to EDS. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

   If I fail to specify an expiration date, event or condition, this authorization will expire in twelve months.

7. I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand that I may inspect or copy information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by privacy rules. If I have questions about disclosure of my health information, I can contact:

   Employers Dental Services
   4720 N. Oracle Road, Suite 100
   Tucson, AZ 85705
   Telephone: 520-696-4343 Fax: 520-696-4311

_____ _____

Signature of Member or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relationship to Member Signature of Witness